

HIV COUNSELING AND TESTING INTAKE RECORD

Name		Date of Visit																																													
Address		Counselor ID No.																																													
County		Zip Code																																													
Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		Date of Birth ____ / ____ / ____																																													
Race/Ethnicity <input type="checkbox"/> White <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Other (Specify): _____ <input type="checkbox"/> Black <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Undetermined																																															
Physical Description (From Observation) Ht. _____ Wt. _____ Hair _____ Comp. _____ Eyes _____ Other _____																																															
Testing Information: <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> Client Previously Tested? <input type="checkbox"/> No <input type="checkbox"/> Yes, Negative <input type="checkbox"/> Yes, Positive <input type="checkbox"/> Yes, Inconclusive <input type="checkbox"/> Yes, Unknown </div> <div style="width: 45%;"> If Yes, Where and Date Tested: _____ _____ </div> </div>																																															
Referred By (Please check): <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> 1 <input type="checkbox"/> Hotline 2 <input type="checkbox"/> Private Physician 3 <input type="checkbox"/> Community Based Organization 4 <input type="checkbox"/> Hospital/Health Center/Clinic </div> <div style="width: 45%;"> 5 <input type="checkbox"/> Literature (Pamphlet, Flyer, Poster) 6 <input type="checkbox"/> Media (TV, Radio, Newspaper) 7 <input type="checkbox"/> Other (Family, Friend, Partner, Word of Mouth, Etc.) </div> </div>																																															
Reason for Testing:																																															
Risk Exposure (Check all that apply): <table style="width: 100%; border: none;"> <thead> <tr> <th style="width: 45%;"></th> <th style="width: 10%; text-align: center;"><u>Last Exposure</u></th> <th style="width: 45%;"></th> <th style="width: 10%; text-align: center;"><u>Last Exposure</u></th> </tr> </thead> <tbody> <tr> <td>A <input type="checkbox"/> Man who had sex w/man</td> <td style="text-align: center;">_____</td> <td>K <input type="checkbox"/> SP-Blood Recipient</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>B <input type="checkbox"/> *IDU</td> <td style="text-align: center;">_____</td> <td>L <input type="checkbox"/> SP-Prostitute</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>C <input type="checkbox"/> Hemophilia</td> <td style="text-align: center;">_____</td> <td>M <input type="checkbox"/> Sex while using non-injecting drug</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>D <input type="checkbox"/> Blood Recipient</td> <td style="text-align: center;">_____</td> <td>N <input type="checkbox"/> Occupational Exposure</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>E <input type="checkbox"/> Heterosexual</td> <td style="text-align: center;">_____</td> <td>O <input type="checkbox"/> Parent with HIV/AIDS</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>F <input type="checkbox"/> *SP-Homo/Bi</td> <td style="text-align: center;">_____</td> <td>P <input type="checkbox"/> Tattoo, Acupuncture or Steroids</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>G <input type="checkbox"/> SP-IDU</td> <td style="text-align: center;">_____</td> <td>Q <input type="checkbox"/> Rape/Sexual Assault Victim</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>H <input type="checkbox"/> SP-PWA/HIV+</td> <td style="text-align: center;">_____</td> <td>R <input type="checkbox"/> STD Diagnosis</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>I <input type="checkbox"/> SP-Hemophiliac</td> <td style="text-align: center;">_____</td> <td>S <input type="checkbox"/> Sex Female to Female</td> <td style="text-align: center;">_____</td> </tr> <tr> <td>J <input type="checkbox"/> Exchanged drugs/ money for sex</td> <td style="text-align: center;">_____</td> <td>T <input type="checkbox"/> No Known Risk</td> <td style="text-align: center;">_____</td> </tr> </tbody> </table> <div style="display: flex; justify-content: space-around; margin-top: 10px;"> *IDU – Intravenous drug user *SP – Sexual Partner </div>					<u>Last Exposure</u>		<u>Last Exposure</u>	A <input type="checkbox"/> Man who had sex w/man	_____	K <input type="checkbox"/> SP-Blood Recipient	_____	B <input type="checkbox"/> *IDU	_____	L <input type="checkbox"/> SP-Prostitute	_____	C <input type="checkbox"/> Hemophilia	_____	M <input type="checkbox"/> Sex while using non-injecting drug	_____	D <input type="checkbox"/> Blood Recipient	_____	N <input type="checkbox"/> Occupational Exposure	_____	E <input type="checkbox"/> Heterosexual	_____	O <input type="checkbox"/> Parent with HIV/AIDS	_____	F <input type="checkbox"/> *SP-Homo/Bi	_____	P <input type="checkbox"/> Tattoo, Acupuncture or Steroids	_____	G <input type="checkbox"/> SP-IDU	_____	Q <input type="checkbox"/> Rape/Sexual Assault Victim	_____	H <input type="checkbox"/> SP-PWA/HIV+	_____	R <input type="checkbox"/> STD Diagnosis	_____	I <input type="checkbox"/> SP-Hemophiliac	_____	S <input type="checkbox"/> Sex Female to Female	_____	J <input type="checkbox"/> Exchanged drugs/ money for sex	_____	T <input type="checkbox"/> No Known Risk	_____
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(COUNSELOR IMPRESSION) Does counselor foresee any problems eliciting/notifying any sex/needle sharing partners if client is HIV positive? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, describe: _____ _____																																															

POST-TEST COUNSELING RECORD

POSITIVE RESULT

Date of Visit: ____ / ____ / ____

Client ID Number: _____

I. Referrals for Medical/Psycho-Social/Support Services

A. Medical Treatment (Specify)

Appt. Date and Time

Other Medical Facility/Clinic _____

Private Physician _____

B. Mental Health/Psychological/Addictions Services (Specify):

Appt. Date and Time

Crisis Intervention _____

Mental Health Center _____

Drug or Alcohol Treatment _____

Private Therapist _____

Other _____

C. HIV Support Services

Name of Program

Appt. Date and Time

II. Contact Elicitation:

A. Number of Sexual Partners: _____

B. Number of Needle Sharing Partners: _____

C. Number of Contacts Referred to NAP: _____ Date of Referral: ____/____/____

COMMENTS:

Counselor ID Number: _____

POST-TEST COUNSELING RECORD, CONTINUED

III. Follow-Up Post-Test Session (Schedule 2 weeks after Initial Post-Test)

Date: ____ / ____ / ____ Time: _____

Appointment kept: ☐ Yes ☐ No

If Yes, any additional social service/mental health referrals made:

1. _____

2. _____

Has client made contact with support services? ☐ Yes ☐ No

Has client sought medical treatment? ☐ Yes ☐ No

Any additional contacts elicited: Sexual # _____ Needle Sharing # _____

Number contacts referred to NAP: _____ Date of Referral: ____ / ____ / ____

COMMENTS:

Counselor ID Number: _____

IV. Counselor Follow-up

Date: ____ / ____ / ____

Appointment kept: ☐ Yes ☐ No

If No, rescheduled?

Date: ____ / ____ / ____ Time: _____

COMMENTS:

Counselor ID Number: _____